# Exploring the relationship between personal and perceived public attitudes of mental health difficulties and professional help seeking: Does self-compassion play a role?

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## Declaration

*This work is original and has not been submitted in relation to any other degree or qualification.*

Signed: 

Date: 02/10/17

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With thanks to my supervisor Gemma Evans for her support and assistance during this research dissertation.

University of Chester

# Department of Psychology

# Research Module Meeting Log 2016/2017

NAME: Rebecca Jones

SUPERVISOR: Gemma Evans

| Date | Discussion topics |
|---|---|
| 31/01/17 | An initial discussion to consider interests, where I would like to take the thesis and how I would like to gather data. |
| 20/02/17 | Decided measures for the survey. Discussed ethics form amendments. |
| 28/03/17 | Discussed the outcome of the ethics form and amendments needed |
| 16/05/17 | Variables decided for study |
| 30/05/17 | Ethics application with me as the main applicant to analyse a sub-section of the data from the larger study |
| 4/07/17 | Dates decided for drafts of each section |
| 31/07/17 | Discussed the analysis section of thesis |
| 11/09/17 | Update chat, confirmation of SPSS analysis to use |

Additional email communication throughout to discuss the dissertation topic, ethics, measures, survey, and dissertation content.

SIGNED STUDENT  DATE: 02/10/17

SUPERVISOR  DATE: 2.10.2017

## Table of Contents

## List of Tables

**Abstract**

Previous literature suggests that there is a relationship between mental health stigma and help seeking attitudes. There are however mixed results when determining the effects of specific elements of stigma: personal stigma and perceived public stigma. There is also limited research into the effects of self-compassion on this relationship, with initial studies suggesting increased self-compassion has a positive impact on the reduction of stigma. The current survey based study of 40 students examined the relationship between personal and perceived public attitudes of mental health difficulties and professional help seeking. The study also examined the role of self-compassion in this relationship. The findings revealed a significant relationship between perceived family and community views of mental health and help seeking. No correlation was found between personal attitudes towards mental health and help seeking. Self-compassion was significantly correlated with personal attitudes towards mental health but not help seeking. Findings indicate that perceived public stigma is an important barrier towards mental health help seeking attitudes and should be the focus of future interventions. Results also suggest that an increased level of self-compassion is associated with more positive personal attitudes towards mental health, indicating that compassion-based therapy is an important and promising tool for reducing stigma and its impacts.

## Introduction

In England, 1 in 6 adults experience a common mental health difficulty such as depression or anxiety. Of those who experience a mental health difficulty, only a third receive professional mental health treatment (McManus, Bebbington, Jenkins & Brugha, 2016). Although a 2014 report in England showed an estimated 4.8% of the population had improved their attitudes towards mental health difficulties since 2011, over half of the respondents (53%) reported experiencing a lot of stigma and discrimination due to their mental health, with a further 34% disclosing that they experience and little (Time to Change, 2014). Different concepts, including stigma, shame, prejudice and discrimination, are incorporated within research into attitudes towards mental health. An overview of the conceptualisation of these broad concepts will be discussed, with a specific focus on mental health stigma.

### The construct of stigma

The construct of stigma has been widely studied both empirically and theoretically and definitions have developed as research has expanded to incorporate different aspects. Goffman's (1963) classic interpretation defined stigma as a discrediting attribute that stereotyped an individual as socially undesirable. Goffman (1963) highlighted that stigma was evident across three different forms; physical stigma, stigma of group identity and stigma of a character trait. Mental health stigma is categorised into the latter due to the stigmatising perception that mental difficulties are a character blemish. Some argue that Goffman's (1963) broad definition of stigma, that encompasses visible and invisible, as well as mental and physical aspects, does not provide an altogether different understanding than concepts such as prejudice (Perez,

2014). Prejudice, defined as people's negative attitudes (Allport, 1954), is often used interchangeably with stigma. However, it has been established that the conceptual models differ in primary focus. Prejudice often surrounds groups such as race, gender and age whereas stigma is directed towards the individual and unusual conditions such as mental health difficulties, disfigurement and HIV (Phelan, Link & Dovidio, 2008). It is argued that stigma encompasses prejudice and discrimination, the behavioural outcome of prejudice (Thornicroft, Rose, Kassam, & Sartorius, 2007). Thornicroft et al. (2007) believe that a focus on understanding ways to reduce discrimination, the behavioural aspect of stigma, will reduce the impact stigma has upon those suffering with mental health difficulties.

Link and Phelan (2001) argue that Goffman's (1963) original stigma concept isolates the problem as a part of the stigmatised individual rather than the label and gives little focus to the discrimination that stigmatised individuals are subjected to. Corrigan's (2000) more modern conceptualisation focuses on the behavioural and cognitive features of mental health stigma whereby the cognitive structures of stereotypes cause the emotional consequence prejudice, which leads to the behavioural outcome of discrimination. The core components highlighted in this concept allow for research into the underlying aspects of stigma and are reflected in Link and Phelan's (2001) more sociological conceptualisation with the combination of discrimination, labelling, stereotyping, status removal and social separation. Link and Phelan (2001) also emphasise the importance of power and how, for stigmatisation to occur, the stigmatising group have to be in a higher position of power within society than the stigmatised group. This concept is believed to provide a more structural view of

stigma and helps to bring further understanding to the issues that stigmatised people face.

Within the body of research surrounding mental health attitudes, stigma is differentiated into different concepts including internalised stigma, perceived public stigma and personal stigma, which will now be discussed in turn.

**Internalised stigma.**

A key element of stigma is whether the attribute at the source of the stigma is visible to society, as differences between individuals have to be noticed and regarded as relevant in order for labelling to occur (Link, Struening, Cullen, Shrout & Dohrenwend, 1989). Stigmatised individuals are categorised by Goffman (1963) as discredited, where the source of their stigma is visible (race or physical illness), or discreditable, where the stigma source is concealable (sexual orientation or mental difficulties). If a discreditable stigma is revealed to society it can become discredited and individuals face the same reduced life chances, such as limited career opportunities, that have been found for those with an originally visible attribute (Judgeo & Moalusi, 2014). In a study of individuals with undisclosed HIV, Judgeo and Moalusi (2014) found that societal and media related stigma led to the internalisation of societies prejudices and subsequently led to individuals withdrawing themselves from society.

Similar internalisation has been found in mental health research. In a longitudinal study of bipolar and schizophrenic patients, concerns of societal stigma were found to influence poorer social adjustment with individuals outside the family (Perlick, 2001). Although this study did not fully address all areas of

social adaptation, omitting adjustment to employment and family situations, it discovered that isolation was used in anticipation of rejection as a coping strategy. This finding is maintained by Link and Phelan (2001) who believe that those who experience internalised stigma are less likely to challenge discrimination and be more accepting of their lower societal status which can lead to feelings of shame, alienation and societal withdrawal (Livingston and Boyd, 2010). The extent of this impact is influenced by the amount of stigma that an individual perceives from society.

**Perceived public stigma.**

An individual's perception of the stigmatising views of mental health difficulties held by the public and has been shown to have detrimental effects on recovery due to the internalisation of the stigma (Corrigan, 2004). Although perceived stigma and internalised stigma are different manifestations, it is argued that perceived stigma influences internalised stigma, as higher levels of public stigma leads to the increased likelihood of the internalisation of the negative stereotypes (Corrigan & Watson, 2004).

Link, Struening, Neese-Todd, Asmussen & Phelan (2001) found that low self-esteem is significantly impacted by stigma due to perceived social rejection and devaluating discrimination that are internalised by mental health sufferers. Although it is possible that an unmeasured variable affected the association between self-esteem and stigma in this study, the longitudinal aspect shows a robust association between the two and, as potential variables such as baseline self-esteem and depressive symptoms were controlled for, it is unlikely that another unmeasured variable could have the strength to affect such a strong

association. Further to this finding, Ritsher and Phelan (2004) found that high levels of alienation, a dimension within perceived stigma, predicted low self-esteem emphasising the impact of the ‘us and them’ divide highlighted by Link and Phelan (2001).

**Personal Stigma.**

Corrigan, Watson and Barr (2006) propose that personal stigma only develops once individuals are aware of public stigma. These views either coincide or differ with the perceived views of the public. Personal stigma then develops into internalised stigma, where the views are applied to the self. Corrigan (2004) notes that an individual’s self-esteem may be harmed if they recognise themselves as having a mental health difficulty that they once stigmatised as being a danger or a weakness, which could then lead to reluctance to seek help for fear of discrimination from others who hold the same views.

It has been shown that education positively affects personal stigma, with extended years in education related to lower levels of personal stigma (Coppens et al., 2013). Interventions utilising an educational approach, alongside interaction between stigmatised individuals and the public, have been shown to successfully reduce stigma (Livingstone, Milne & Fang, 2011). Gender and age also play a role; with males and an increase in age related to a rise in personal stigma levels (Coppens et al., 2013).

It is often noted that levels of personal stigma are lower perceived public stigma views (Eisenberg, Downs, Golberstein & Zivin, 2009; Coppens et al., 2013; Pedersen & Paves, 2014) and although this could be affected by

desirability bias, whereby individuals do not want to reveal their undesirable attitudes towards mental health, it indicates that there is an amplified interpretation of the public's view of mental health. This is highlighted by Pederson and Paves (2014) who found that one third of participants believed they would be treated differently by their peers if they were treated for a mental health illness, but three quarters reported that they would not treat a peer differently if they sought mental health treatment.

An individuals personal thoughts and beliefs about mental health difficulties as well as their perceived view of societies stance on mental difficulties are generally believed to affect help seeking behaviour in relation to a mental health problem (Barney, Griffiths, Jorm & Christensen, 2006; Griffiths, Christensen & Jorm, 2008). Internalisation of the public's stigma has been found to facilitate health care avoidance and impacts upon mental health treatment adherence (Sirey et al., 2001a; 2001b; Vogel, Wade & Hackler, 2007).

**The concept of help seeking**

Initial models suggest that the help seeking process is made up of multiple stages, incorporating the perceived need for professional help, the predisposition to receive help, the benefits or detriments of receiving treatment (with the consideration of social norms) and the action of receiving care (Mechanic, 1966; Rosenstock, 1966; Anderson, 1968). Previous literature indicates that the stigma surrounding mental health has significant adverse affects on help seeking behaviours when individuals take into account the benefits of treatment in regard to the social norms and how receiving professional care for a mental health difficulty may affect their social status (Eisenberg et al., 2009). In terms of the stigma surrounding the use of mental

health services, Vogel, Wade and Haake (2006) state that “the perception that a person who seeks psychological treatment is undesirable or socially un-acceptable” (p. 325) leads to the denial of psychological concerns. This action, defined as label avoidance (Corrigan & Matthews, 2003), is used to avoid the harmful consequences of stigma, and therefore has detrimental effects on the potential resolution of mental health difficulties, perpetuating the concerns surrounding stigma.

It has also been noted that friends and family are a preferred source of help over health professionals, with 59% of adults choosing to talk to a family member compared with 34% taking advice from a doctor (Walters, Buszewicz, Weich & King, 2008). Although multiple factors have been found to effect help seeking including age, education, gender and ethnicity (Eisenberg, Golberstein & Gollust, 2007; Scott & Walter, 2010), the impact of mental health attitudes and stigma on help seeking, will be the focus of this thesis with different areas of help seeking including adherence and avoidance to be discussed.

**The effects of stigma on help seeking**

The effect of mental health stigma on help seeking behaviour is a deliberated subject within research. It is suggested that 70% of people worldwide do not receive treatment for mental health concerns and of those who engage with treatment, the majority are found to have no difficulties (Thornicroft, 2007). This suggests that those who would benefit the most from mental health care are not seeking it. Stigma may play a possible role in the avoidance of help seeking, however the literature is mixed in this area of research.

**Mental health care avoidance.**

The acceptance of a lower societal status caused by internalised stigma has been found to mediate the pathway towards health care avoidance for mental health difficulties (Vogel et al., 2007). In a US sample it was found that a quarter of individuals who perceived a need for psychological help did not seek assistance from a health professional due to concerns for what others might think (Kessler et al., 2001). In contrast with previous studies (Fuller, Edwards, Procter & Moss, 2000; Wrigley, Jackson, Judd & Komiti, 2005; Clement et al., 2015) Kessler et al. (2001) used semi-structured interviews and found that perceived stigma was the most uncommon treatment barrier compared with situational or financial barriers for participants in rural communities. This is potentially due to a stronger feeling of support in a smaller community setting however more research needs to be done in this area as causality was not analysed in this study. Whilst this study included measures of actual help seeking, furthering previous research that uses only intention to seek help measures (e.g. Barney et al., 2006), interviews may have been impacted by social desirability bias and anonymous questionnaires may have been an alternative methodological choice. The use of an anonymous questionnaire may have reduced the prevalence of desirability bias and increased the accuracy of the help seeking measure.

Similar results were found by Pedersen and Paves (2014) who, using a student sample, found that less favourable attitudes towards seeking mental health care were affected by a greater perceived view that the public would view them negatively. This study reviewed both attitudes and experience of help seeking as well as different mental health diagnoses. Higher reported anxiety

symptoms led to an increase in perceived public stigma, however no effect was found for depression or alcohol related illness. Although caution should be taken due to this study's unrepresentative sample of predominantly female psychology undergraduates from one university, it does suggest an interesting finding that public stigma varies for different diagnoses and the effect of stigma on different mental health difficulties has an affect on the help seeking behaviours of those suffering.

Jorm et al. (2000) also found support for different diagnoses having different associated stigma. In a survey-based study on depression sufferers over a 6-month period, no association was found between perceived public stigma and active mental health service use. The study also found that depression was viewed positively in comparison with other mental health difficulties. Once again, this suggests that depression fosters different stigma than other mental health diagnoses and sufferers are not as affected by perceived public stigma. A limitation of this study is that perceived public stigma was assessed with one question asking about discrimination ("Do you think that Mary would be discriminated against by others in the community if they knew about the problems she has had?" p. 614), for which reliability data was not provided. As previously discussed, discrimination is one element of stigma and to only assess one component impacts on the quality of the perceived public stigma measure for this study.

In contrast to the above findings by Kessler et al. (2001) and Pedersen and Paves (2014), a large US student study looking at different aspects of stigma found that perceived public stigma was un-associated with actual help seeking whereas personal stigma was significantly associated with many

aspects of help seeking (e.g. the use of medication, therapy and nonclinical sources). The study used a random sample of students from 13 different universities increasing the generalisation of the results to the wider population. Using the phrase “most people” in each item (e.g. “Most people think less of a person after he/she has been hospitalized for a mental illness”), may however have made it difficult for respondents to ascertain whether the questions about perceived stigma were about society in general or their fellow students, making it a less reliable than the personal stigma instrument. Eisenberg et al. (2009) concluded that personal stigma is a bigger barrier to mental health than perceived stigma and, although causality was not addressed in this study, the authors suggested that causality runs both ways, with personal stigma inhibiting help seeking, but help seeking equally reducing personal stigma.

In a more recent study with a European sample, similar results to the above study were found when perceived social stigma scales did not correlate with any of the multi-item attitudes towards seeking professional help scales in relation to depression (Coppens et al., 2013). There was however, a significant association between personal stigma and less openness to professional treatment. This methodological approach using internationally validated surveys gained significant results across four different European countries, allowing more of an understanding of stigma across different countries and cultures. The study does however use regionalised samples from each country meaning the data may not be generalised to the whole population. Secondly, as with most studies with a focus on the impact of stigma on help seeking, this study is cross sectional and therefore provides no causal explanations.

**Mental health care adherence.**

Perceived public stigma has also been shown to affect patient's adherence to mental health treatment. Sirey et al. (2001a; 2001b) reported that higher perceived public stigma produced adverse affects on the adherence to antidepressant medication and, in the case of older patients, predicted treatment discontinuation; supporting the finding that age affects the use of mental health services (Leaf, Bruce & Tischler, 1986). Although consistent with the view that stigma has a greater effect once treatment is initiated and mental difficulty becomes a reality for the patient (Link et al. 1989), the self-disclosure method used in these studies may have been effected by the honesty of the participants, therefore an additional way of assessing medical adherence using a medical or peer review could have been used to verify the patients self-report.

Although many of these studies indicate that perceived public stigma is more prevalent than personal stigma (Coppens et al., 2013; Eisenberg et al., 2009) results suggest that findings surrounding the impact of stigma and help seeking are inconsistent. Different methodologies, mental health focus and samples may play a role in this. The contradictory results found between the relationship of perceived public stigma and professional help seeking may be due to the differences between how stigma was assessed in the studies. When defining perceived stigma some studies referenced community views whereas others indicated a general society view and some used the ambiguous phrase 'most people'. This makes it difficult for the participant to answer the items on perceived bias accurately when they are unsure of which area of society they should be referring to and it may be that they are more concerned about the attitudes of friends and family than they are about 'most people' whom they may not know. It is easier to compare the results of personal stigma instruments as participants are aware they are answering is regard to their own views, with no

ambiguity present. In the study presented within this thesis, this methodological issue was addressed by using specific items for community attitudes and family attitudes of mental health, ensuring no uncertainty surrounded the perceived stigma aspect of the study.

Within the reported studies, there have also been attempts to assess a number of additional factors that may impact the relationship between perceived stigma and help seeking. The current study aimed to examine the impact of self-compassion on this relationship.

**Self-compassion**

Self-compassion, a relatively new concept in Western psychology, is a positive self-attitude, comprised of three main components: self-kindness (being kind to oneself in times of hardship), common humanity (perceiving oneself as part of a wider picture rather than having an isolated outlook) and mindfulness (living in the present moment by balancing positive and negative thoughts rather than over-identifying with the negatives) (Neff, 2003). Given the self-kindness element of self-compassion, this concept appears to be a potentially important variable in understanding stigma and help seeking. Stemming from the awareness of feelings and non-judgemental aspects of compassion and combatting the negative aspects of self-esteem (such as depression and narcissism: Baumeister, Heatherton, & Tice, 1993), self-compassion has increased in popularity over the last decade. A growing body of literature suggests that self-compassion influences improved emotional wellbeing, which has led to the emergence of compassion focused therapy, which draws on the concept of compassion (Neff & Dahm, 2015).

As one of the main features of self-compassion is the reduction of self-criticism, whish is a predictor a depression and anxiety (Blatt, 1995); it is feasible that an increase in self-compassion were related to a reduction of depression and anxiety symptoms and an increase in life satisfaction. In confirmation of this hypothesis, a meta-analysis of 20 studies assessed the link between self-compassion and psychopathology and found that higher levels of compassion lead to a decrease in mental health symptoms (MacBeth & Gumley, 2012). It has been found that self-compassion deactivates the threat system associated with depression and anxiety by lowering the levels of cortisol, allowing individuals to feel safe (Gilbert & Irons, 2005; Rockcliff, Gilbert, McEwan, Lightman & Glover, 2008).

**Self-compassion and stigma.**

As self-compassion has been associated with an increase in life satisfaction, happiness and optimism (Neff, 2003; Neff, Kirkpatrick & Rude, 2007), it is fair to hypothesise that an increase in self-compassion may reduce stigmatising thoughts towards those suffering in life. Neff, Kirkpatrick and Rude (2007) found a link between self-compassion and affective wisdom. Affective wisdom suggests that concerns about the self and others are linked, allowing individuals to direct emotions such as sympathy and kindness towards others, as well as themselves. However, it is proposed that as the majority of positive feelings are directed towards the self, stigmatising thoughts towards others may be increased in those with high self-compassion. In argument against this interpretation, Neff (2003) states that self-compassion involves acknowledging that suffering is part of the common human experience and that everyone is worthy of compassion.

In a study assessing the role of self-compassion as a mediator between stigma and mental and physical health in an obese sample, it was found that self-compassion intervened in the association between internalised-stigma and depression, lowering the effect by one third (Hilbert et al., 2015). Wong, Mak and Liao (2016) similarly explored the role of how self-compassion mediates the effect of affiliate stigma. Affiliate stigma is classified as shame by association, where the family of the stigmatised person internalises the stigma received by their ill or disabled family member, and has been shown to impact a person's psychological well being (Banga & Ghosh, 2016). Wong et al. (2016) explored affiliate stigma in parents of autistic children and found that self-compassion was a protective factor in the relationship between affiliate stigma and psychological distress. Affiliate stigma was only associated with psychological distress when the self-compassion of the participants was low. Similar results have been found where self-compassion has been shown to buffer against the effect that perceived public stigma has on internalised stigma (Heath, Brenner, Lannin & Vogel, 2016). Self-compassion was found to provide individuals with the psychological resilience needed to avoid applying the perceived views of society to the self. The study did not, however, assess the impact of self-compassion on personal stigma, a drawback resolved in the current study.

Although the research into self-compassion and its effects on stigma is limited, with further research needed to assess different stigmas, the current studies suggest that the use of compassion-based therapy to increase psychological resilience could be a promising tool in the reduction of stigma related impacts.

## Hypotheses

The current survey-based study measures participants' personal and perceived attitudes towards mental health, their self-compassion and their attitudes towards seeking professional help in an aim to explore the impact that different types of stigma have on help seeking and the role that self-compassion plays within this relationship. The evidence discussed above suggests that stigma will be associated with negative views of help seeking and higher levels of self-compassion will reduce stigma and the impact it can have on psychological wellbeing and behaviour. The hypotheses for this study are as follows.

1) Personal attitudes towards mental health difficulties will be associated with professional help seeking attitudes.
2) Perceived family and community attitudes towards mental health difficulties will be associated with help seeking
3) Self-compassion will be associated with personal attitudes towards mental health difficulties
4) Self-compassion will be associated with professional help seeking attitudes

# Method

## Participants

Forty-one participants, with current student status of an age of 18 and above took part in the study. To guarantee a student sample, one participant was removed from the data because they failed to specify their student status. From the 40 remaining participants, 11 were male and 29 were female with an age range of 19 to 59 (Mean = 26, SD = 9.73). Participants were recruited via the University of Chester's Research Participation System (RPS) and through the researcher's social media. University of Chester students were offered 2 RPS credits for the completion of the study, which the researcher awarded anonymously.

Participants were required to provide their student status but to protect their anonymity, no further questions were asked about their graduate status or the university that they attended. The study received ethical approval from the Committee at the University of Chester (Appendices D & E) and complied with the ethical code of conduct from the British Psychological Society.

## Measures

The data used in this study are taken from part of a larger study, which included additional measures of physical health status and physical health stigma. However, the data from three measures were used for the current study. The three measures are the Self-Compassion Scale (Appendix A**:** Neff, 2003), the Attitudes Towards Mental Health Problems scale (Appendix B: Gilbert et al., 2007) and the Attitudes Towards Seeking Professional Help Short Form (Appendix C**:** Fischer & Farina, 1995).

### Self-compassion scale.

Participants' self-compassion was measured using the self-compassion scale (Neff, 2003). The 26-item scale assessed the six different components of self-compassion: Self-Kindness (e.g. "I try to be loving toward myself when I'm feeling emotional pain"), Self-Judgement (e.g. "When times are really difficult I tend to be tough on myself"), Common Humanity (e.g. "When things are going badly for me I see the difficulties as part of life"), Isolation (e.g. "When I think about my inadequacies it tends to make me feel more separate and cut off from the rest of the world"), Mindfulness (e.g. "When something painful happens I try to take a balanced view of the situation") and Over-Identification (e.g. "When something upsets me I get carried away with my feelings"). Responses were given on a five-point scale in terms of how often the participant felt or behaved in that way from 'almost never' to 'almost always'. The negative aspects of the scale, Self-Judgement, Isolation and Over Identification, were reverse coded.

Neff (2003), in the development of the original self-compassion scale, showed that the scale demonstrated good internal consistency reliability ($\alpha$ = .92) and had good test-retest reliability ($\alpha$ = .93: Neff, 2003). All six subscales have been shown to be highly inter-correlated in two student samples and allow the scale to be analysed as a whole or as separate subscales (Neff, 2003; Neff, Kirkpatrick & Rude, 2007). More recent studies using the self-compassion scale have found similar internal consistency reliability for the full scale ($\alpha$ = .96) and the six subscales (ranging between $\alpha$ = .78 and $\alpha$ = .93) (Werner et al., 2012). Some argue that a true self-compassion scale should not measure uncompassionate behaviour and instead propose a two-factor model where the positive subscales measure self-compassion and the negative subscales measure self-criticism (López et al., 2015; Muris, 2016). However, Neff (2015)

believes that a two-factor model of the self-compassion scale would limit its ability to assess the impact that the various components of self-compassion has on wellbeing. An overall self-criticism factor would not have allowed for the finding that isolation is a bigger predictor of depression than self-judgement (Körner et al., 2015). Given this, the current study used the six subscales of the self-compassion scale to create an overall combined self-compassion score.

**Attitudes towards mental health problems scale.**

To assess personal views and perceived family and community views of mental health, two subscales of the Attitudes Towards Mental Health Problems scale was used. The study utilised the community and family subscale as well as the internal shame subscale, forming an 11-item scale (Gilbert et al., 2007). The remaining three subscales of 24 items were omitted from this study to reduce the likelihood of inducing negative emotion in the participants, a requirement of the research ethics committee. Responses were given to the internal shame items (e.g. “I would see myself as inferior”) and the family and community items (e.g. “My community sees mental health problems as something to keep secret”) on a four-point scale from ‘do not agree at all’ to ‘completely agree’.

Gilbert et al. (2007), in the development of the attitudes towards mental health scale, suggested that the scale was developed as a set of individual subscales, each with face validity. The subscales therefore had good internal reliability achieving a Cronbach’s alpha of $\alpha$ = .85 and $\alpha$ = .97 across Asian and non-Asian students. The scale has been reliably used in student samples assessing gender differences, with a subscale reliability of $\alpha$ = .85 to $\alpha$ = .97

(Hampton & Sharp, 2013) as well as the attitudes of medical professionals, with a subscale reliability of $\alpha$ = .50 to $\alpha$ = .90 (Ghai et al., 2013).

**Attitudes towards seeking professional help short form.**

The attitudes towards seeking professional help short form (Fischer & Farina, 1995), was used to assess participants' opinions on seeking help for mental health problems. The shortened version was developed from Fischer and Turner's (1970) original 29-item scale by selecting the items with the largest item-total score and factor analysing them. This final shortened form includes two factors: recognition of need for help and confidence in the health professional. The short form has validated internal consistency ranging from $\alpha$ = .82 to $\alpha$ = .84 and correlates with the original scale at $r$ = .87 (Fischer & Farina, 1995). The short form has also been verified in a sample of 296 students when it demonstrated a coefficient alpha of $\alpha$ = .77 (Elhai, Schweinle & Anderson, 2008). Criterion validity was also confirmed in this study when recent mental health service users scored higher on the attitudes towards seeking professional help scale compared with less frequent service users (Cohen's $d$ = .74).

The ten-item scale asks participants positively framed questions such as "I might want to have psychological counselling in the future" and negatively framed questions such as "A person should work out his or her own problems; getting psychological counselling would be a last resort". The negatively framed questions were reversed coded. Responses were given on a four-point likert-type scale with the options of 'disagree', 'partly disagree', 'partly agree' or 'agree'.

## Procedure

The study was advertised on RPS, the University of Chester's study advertising system, through the researchers social media and through posters displayed around the psychology department at the University of Chester. Participants who engaged with the study on RPS completed an online survey through the RPS site. Participants who showed interest in the study on social media were sent a link for the Bristol Online Survey's version of the survey after the researcher ensured they met the eligibility criteria by being over the age of 18 and holding a current student status. Participants, recruited using RPS and social media, completed the online survey after reading the participant information sheet (PIS). No deception was used in the study and essential information was given to the participant in the PIS and debrief form along with contact information of the researchers. Progression past the PIS served as consent for the study and participants were able to end the survey at any time by ceasing the completion of the questionnaire. To combat feelings of negativity that may have been induced by the survey, links to amusing videos were shown once participants had finished.

## Analysis and Design

The cross sectional study is centred on responses to a self-report survey made up of the measures reviewed above. The total scale mean was used to replace missing data for any individual scales that contained two or less missing data points to ensure data could be used from every participant. All participants were included in the data analysis as no participants had more than two data points missing. Once the data had been entered into IBM SPSS, a Shapiro-Wilk test was used to establish whether the data was normally distributed. Although

the overall data for the self-compassion scale showed normal distribution, the Shapiro-wilk test showed that the family and community attitude towards mental health scale, personal attitude towards mental health scale and ATSPH-SF data was not normally distributed. Due to this, Spearman's correlation coefficient was used to analyse the relationships between both personal and family/community views of mental health and help seeking attitudes, self-compassion and personal views of mental health and self-compassion and help seeking.

## Results

| | Means (SD) | Cronbach α |
|---|---|---|
| Self-compassion | 3.01 (0.74) | 0.82 |
| Community and family attitudes towards mental health | 13.15 (4.63) | 0.84 |
| Personal attitudes towards mental health | 11.23 (5.11) | 0.95 |
| Attitudes towards seeking professional help | 27.75 (5.49) | 0.78 |

The mean scores for each measure are displayed below in Table 1 alongside the standard deviations and Cronbach alphas. All measures are shown to have an adequate internal consistency, according to Nunnally (1978) who states that reliability above 0.7 is acceptable.

Table 1
Means and standard deviations (SD) with Cronbach's α for all measures

The maximum score that participants could report for the self-compassion scale, calculated as an overall mean, was 4.33. A higher score on the self-compassion scale signifies a higher level of self-compassion with the mean for this study suggesting that participants reported a relatively high level of self-compassion. Participants could report a maximum score of 32 for

community and family attitudes towards mental health scale and 20 for personal attitudes towards mental health scale. For these two measures, a high score indicates a negative view of mental health. Results show that participants' personal view of mental health is slightly more positive than their perceived view of the public's attitude towards mental health. Finally, the highest score participants could report for the attitudes towards seeking professional help scale was 36. A higher score in this scale denotes a more positive attitude towards seeking professional help. The mean in this study suggests that participants have a generally positive view of professional help seeking.

To analyse whether the data was normally distributed a Shapiro-Wilk test was used alongside visual inspection of data distribution graphs. The data from the self-compassion scale ($w(40) = 0.98$, $p = 0.759$) and attitudes towards seeking professional help scale ($w(40) = 0.96$, $p = 0.165$) showed normal distribution on the Shapiro-Wilk test. The attitudes towards seeking professional help scale did however show a random distribution on visual inspection of the data distribution graphs. The data from the community and family attitudes towards mental health scale ($w(40) = 0.90$, $p = 0.001$) and the personal attitudes towards mental health scale ($w(40) = 0.90$, $p = 0.002$) were not normally distributed. As the majority of measures were not normally distributed, a non-parametric, Spearman's correlation test was used for further analysis.

Correlational analysis was used to test the associations between the four variables. The relationship between help seeking attitudes and both personal and perceived attitudes towards mental health were examined for associations. The relationship between self-compassion and personal attitudes towards

mental health was also analysed as well as the role self-compassion has on help seeking attitudes.

**Hypothesis 1**

The first hypothesis is that personal attitudes towards mental health difficulties would be associated with professional help seeking attitudes. The association between the personal attitudes towards mental health scale and the attitudes towards seeking professional help scale was analysed using Spearman's correlation. It was revealed that there was neither a positive or negative significant correlation between the personal views of mental health and views of professional help seeking for mental health ($r_s(38) = -0.08$, $p= 0.638$).

**Hypothesis 2**

The second hypothesis was that perceived family and community attitudes towards mental health difficulties would be associated with help seeking. Spearman's correlational analysis revealed a significant, negative correlation between the perceived family and community attitudes towards mental health scale and the attitudes towards seeking professional help scale ($r_s(38) = -0.39$, $p= 0.013$) supporting the hypothesis with a weak association. This suggests that a higher score on the perceived family and community attitudes towards mental health scale, which represents a more negative view of mental health, was linked with a lower score on the attitudes towards seeking professional help scale, which signifies a more positive attitude to professional help seeking.

**Hypothesis 3**

The third hypothesis, suggested that self-compassion would be associated with personal attitudes towards mental health difficulties. Spearman's correlation analysis showed that there was a significant negative correlation between the self-compassion scale and the personal attitudes towards mental health scale ($r_s(38) = -0.53$, $p < 0.001$) with a moderate relationship between the two variables. This suggests that a higher score on the self-compassion scale, representing a more compassionate view of the self, was associated with a lower score on the personal attitudes towards mental health scale, representing a more positive view of mental health.

### Hypothesis 4

The final hypothesis was that self-compassion would be associated with professional help seeking views. Spearman's correlational analysis showed that there was no significant relationship between the self-compassion scale and the attitudes towards seeking professional help scale ($r_s(38) = -0.04$, $p= 0.800$).

## Discussion

### Findings and Implications

The aim of this study was to understand the relationship between different types of mental health stigma, personal attitudes towards mental health and perceived family and community attitudes towards mental health, on help seeking attitudes and establish whether self-compassion plays a role within this relationship. The study revealed 4 main findings:

a) No significant relationship was found between personal attitudes towards mental health and help seeking attitudes.

b) Perceived family and community attitudes towards mental health was significantly associated with attitudes towards help seeking showing a weak relationship.
c) Self-compassion was significantly associated with personal attitudes towards mental health showing a moderate relationship.
d) No significant relationship was found between self-compassion and help seeking attitudes.

Focussing on the first main finding, the study found no correlation between personal attitudes towards mental health and help seeking attitudes, resulting in the rejection of the first hypothesis. This shows that participants' personal views of mental health, either positive or negative, had no association with their attitudes towards seeking professional help for mental health difficulties. This finding contrasts with previous research that found that increased personal stigma is significantly associated with a decreased use of medication and psychotherapy (Eisenberg et al., 2009) as well as people's openness to receive help for their mental difficulties (Coppens et al., 2013). Although this study used a student sample similar to previous studies, further methodological differences between these studies may explain why the different results have occurred.

Firstly, social desirability may have influenced participants' answers on the personal attitudes towards mental health measure. Individuals who were aware that their views of mental health difficulties were socially undesirable may not have given honest answers, leaving the personal attitudes towards mental health scale an understated measure within the study, which may have

impacted on the significance of the relationship when the correlation analysis was performed. However, the survey aspect of the study is likely to have alleviated this effect. Participants were not required to disclose their name and were assured that their survey would remain anonymous, reducing the impact of social desirability to a minimum.

This finding may also be due to different stigmas affecting different help seeking behaviours. In a previous study, personal stigma predicted a decrease in treatment seeking whereas perceived public stigma predicted dropping out of mental health treatment (Britt, Jennings, Cheung, Pury and Zinzow, 2015). Whilst the results in the current study seem to contradict this finding, it is important to recognise that a measure for actual help seeking was not utilised in this study. The attitudes towards seeking professional help scale only assessed attitudes towards help seeking and did not measure specific behaviours seen in the Britt et al. (2015) study. A measure assessing help seeking behaviour was not suitable for the student sample used in this study and would require a clinical sample of patients with mental health difficulties to yield appropriate results. To ascertain whether different stigmas affect different help seeking behaviours, a more detailed help seeking measure, that assesses actual help seeking and adherence to the treatment, may have provided a different insight into stigma related impacts and would help to advise how mental health treatments can be utilised fully by those in need.

In support of the second hypothesis, it was found that perceived family and community attitudes towards mental health were negatively associated with help seeking attitudes. Although a weak association was shown, participants in

this student sample who scored highly on the perceived family and community attitudes towards mental health scale had lower scores on the attitudes towards seeking professional help scale. This result suggests that individuals who believe their family or community have more negative views of mental health difficulties are more likely to have a negative attitude towards mental health help seeking. This suggests that they are therefore less likely to seek professional help for mental health difficulties, which supports previous studies that also found that less favourable attitudes towards seeking professional care were impacted by concerns of negativity from the public (Kessler et al., 2001; Pedersen & Paves, 2014). It is however important to bear in mind that the correlation analysis used in this study has not allowed for causality to be established and only allows for the associations to be discussed.

Although gender was not assessed as a variable in this study, females make up the majority of the sample and it is important to consider that this may have had an impact on the results. Gender differences are prominent for mental health conditions and differ across different age groups and cultures (Afifi, 2007). The finding that females are linked to more positive help seeking attitudes is also evident from adolescence (Chandra & Minkovitz, 2006) into adulthood (Mackenzie, Gekoski & Knox, 2006) with females having a greater association with openness to seek help and acknowledgement of psychological problems than males. As gender was not assessed individually in this study, a female majority may have led to an outcome of more positive help seeking attitudes than an even distribution of males and females would have revealed. Afifi (2007) states that due to the differences seen between the genders, interventions involving mental health cannot be gender neutral and therefore; a

further study, using gender as a variable, will be able to provide the information needed to inform specific interventions for males and females. Males who have reached a higher level of education have been found to have an improved attitude towards help seeking (Mackenzie, Gekoski & Knox, 2006) suggesting that education-based interventions may be best suited for this demographic group.

As existing research shows, personal stigma and perceived stigma develop into internalised stigma, where the negative views are applied to the self, which is then thought to have an impact on help seeking behaviour (Corrigan, 2004; Corrigan, Watson and Barr, 2006). Importantly, at a time when research is debating the impact of the different types of stigma in order to develop successful public campaigns and therapies, this study provides more support to the suggestion that perceived stigma has more of an influence on the internalisation of negative attitudes than personal stigma. Coupled with the fact that perceived stigma is the more predominant stigma recorded in this study, as with prior studies (Coppens et al., 2013; Eisenberg et al., 2009), it is understandable that it has a bigger impact on the application of the negative views on the self and therefore on help seeking behaviours.

Importantly, this finding gives more impetus to find a successful way to reduce perceived public stigma. In a meta-analysis of stigma interventions, it was found that more interventions focus on the reduction of personal stigma, with previous interventions aimed at reducing perceived public stigma failing to be a successful tool (Griffiths, Caron-Arthur, Parsons & Reid, 2014). Individuals tend to overestimate the levels of stigma from the public, with higher prevalence

for perceived stigma than personal stigma seen in this study as well as previous studies (Coppens et al., 2003; Eisenberg et al., 2009). In light of this, Griffiths et al. (2008) suggest that public campaigns should publish actual levels of personal stigma to inform people that the publics' stigma is not as great as they perceive. This may be a particularly successful for student campaigns, where the campus-based community can be easily targeted with information through social media campaigns and educational interventions. By correcting the misperceptions individuals have about their fellow students' attitudes towards mental health difficulties, this may reduce perceived stigma and increase help seeking behaviours. It is also important to continue interventions aimed at reducing personal stigma. Although personal stigma was not related to help seeking in this study, previous studies have shown that personal stigma does play a part. Educational interventions that utilise testimonials from mental health sufferers help to reduce the target audiences' personal stigma, but at the same time reduces perceived public stigma of those providing the testimonial, as they have an active role in changing the views of other individuals (Corrigan, Larson & Rüsch, 2009). Interventions that aim to reduce both personal and perceived stigma are a great option when research shows such uncertainty as to which stigma has the biggest impact on help seeking behaviours.

In terms of the third main finding, the study shows that self-compassion is significantly associated with personal attitudes towards mental health. The moderate, negative relationship shown by the data suggests that individuals who are more self-compassionate have a more positive attitude towards themselves if they were to develop a mental health difficulty. As limited research has been conducted in this area it is difficult to compare these results to prior

studies, however it does show that self-compassion equips individuals with the knowledge that suffering is a common human experience that deserves compassion (Neff, 2003). When individuals acknowledge the reality that mental health difficulties are out of the control of human influence, the struggles experienced are not taken so personally.

In previous research, self-compassion has been known to reduce the effects of perceived public stigma on internalised stigma (Heath et al., 2016). In the current study, the relationship seen between self-compassion and personal stigma suggests that a similar effect occurs. Results show that self-compassion reduces personal stigma, which suggests that it potentially reduces the effects of the internalisation of the stigma. This suggestion would have been further reinforced if the first and last hypotheses were supported. However no relationships were found between self-compassion and help seeking attitudes or personal attitudes towards mental health and help seeking attitudes. This suggests that although self-compassion reduces personal stigma, it may not have an impact on help seeking behaviours. It is, however, important to note that mediation was not analysed in this study, so this statement is speculative from the results gathered. Previous studies do in fact support the final hypothesis. Allen and Leary (2010) state that self-compassionate people rely less on avoidance and escape as a coping mechanism and more on positive actions, involving cognitive restructuring. This suggests that those with high self-compassion are more likely to seek professional help for mental health difficulties, rather than choosing to cope on their own. Due to these contrasting findings, more research is needed to establish whether self-compassion is a

true mediator between mental health stigma and help seeking to inform stigma and self-compassion based interventions.

Due to the link between increased self-compassion and a decrease in negative attitudes towards mental health difficulties, it is important that future research tests interventions or therapies that aim to increase self-compassion with a goal of reducing mental health stigma. Compassion-focused therapy (CFT) has shown that developing a sense of warmth and emotional responsiveness in individuals decreases feelings of shame and inferiority (Gilbert & Procter, 2006). The personal attitudes towards mental health scale used in this study focussed on internal shame, which involves individuals disclosing their feelings of self-devaluation and criticism in relation to mental health. Those with high self-compassion have the ability to see automatic negative emotions and thoughts of shame as safety behaviours (Gilbert & Procter, 2006). Safety behaviours involve automatic thoughts of devaluation of the self in line with the perceived expectations of others. CFT helps individuals to see that safety behaviours are automatic reactions that are not their fault, which allows them to understand their emotions and be less self-critical. From this, it is understandable that higher levels of self-compassion led to a decrease in negative personal views of mental health, as individuals may have shown more compassion towards themselves and their emotions. In future, CFT should be studied alongside different stigmas to ascertain how it can be used to reduce mental health stigma as a whole.

**Strengths and Limitations**

There are a number of limitations that may have impacted upon the findings of the study. Methodologically, the first limitation is that the findings do not show causality, and only reveal associations between the variables. This limits the conclusions that can be drawn from the significant relationships found. Secondly, the study relied on self-report, which means social desirability bias may have had an impact on the truthfulness of participants' responses. However, unlike previous studies that used face-to-face interviews, which are thought to increase the likelihood of bias (Kessler et al., 2001), this study utilised an online, anonymous survey. Participants were only asked to disclose their gender and age and were assured that their individual responses would be kept anonymous, limiting the likelihood of desirability bias having and effect on the results. Another methodological limitation of this study is that internalised stigma was not assessed. Due to ethical fears that the remaining subscales of the attitudes towards mental health scale would induce negative emotions in participants, further sections looking at shame were omitted from the survey. These subscales may have provided a more thorough indication of how individuals would feel if they had a mental health difficulty. As previous research suggests that it is internalised stigma that affects help seeking behaviours, the omission of this aspect of the stigma process limits the ability to ascertain how perceived stigma and personal stigma impacts on individuals' help seeking behaviours and choices.

Although the sample of students was small (n=40), results were similar to previous findings that were reported in larger studies with student samples (Kessler et al., 2001; Pedersen & Paves, 2014). The sample was made up of student participants, rather than a clinical sample of mental health patients, and therefore active help seeking for mental health difficulties was not assessed.

Instead individuals indicated their attitudes towards help seeking. Although attitudes are an indication of help seeking behaviours or intentions, a true help seeking measure should be used in future studies, utilising a longitudinal methodology to assess effect over time. It could be argued that the sample of students affects the external validity of the study and limits its generalizability to the wider population (Kam et al. 2007). Students are believed to be at the age when mental health difficulties can increase which could cause the rapid development of negative attitudes towards mental health difficulties, affecting study findings (Eisenberg et al., 2007). However, the age range of the participants in this study spans forty years (19-59), which increases the external generalizability of the study and limits the worries surrounding biased results due to age. Young adults are known to have more negative attitudes towards help seeking (Mackenzie, Gekoski & Knox, 2006), however it is unknown whether the mean age of 26 impacted the help seeking measure in this study and age was not utilised as a variable. Future research should investigate the impact that age has on the variables in this study to ensure that interventions are directed at the correct age group.

The use of unambiguous wording in the perceived stigma measure has provided consistency across the stigma measures. By avoiding the use of “most people” in the wording of the perceived attitudes measure by using specific items for community attitudes and family attitudes of mental health, ensured no uncertainty surrounded the perceived stigma aspect of the study and, as with the personal attitudes measures, guaranteed the participants knew who they were answering the questions about. This study has provided a consistent measurement of stigma unlike similar studies utilising the phrase “most people”

in perceived stigma measures (e.g. Eisenberg et al., 2009) in which differing results have been found. This gives confidence in the result that perceived stigma has a bigger impact on help seeking attitudes than personal stigma. It is, however, important to call attention to the specific wording of the attitudes towards mental health scale and how items utilise the phrase “like anxiety and depression” when asking about participants attitudes. This leads participants to base their answers on the opinions they hold for a specific type of mental health difficulty. If the questions used the phrase “like schizophrenia” the results may have differed as people often view those who have schizophrenia as being dangerous and unpredictable (Angermeyer & Matschinger, 2004) and may have more negative views surrounding this condition. For future studies looking at general mental health stigma, measures that do not impact upon participants’ thought processes by providing an example of a mental health difficulty may be best suited.

Another key factor that could have been addressed in this section of this study is the perceived stigma from medical professionals. It is reported that stigma directed at service users by healthcare professionals, whether conscious or unconscious, is a major factor in mental health stigma and negatively effects help seeking behaviours (Bates & Stickley, 2013). Thornicroft (2006) reports that, during their recovery, patients experienced the most distress and stigma when accessing healthcare services. This suggests that it could be a key factor in deterring help seeking and needs to be studied further to assess whether it is has similar detrimental effects as perceived stigma of family members or the community that is seen in this study.

## Conclusion

Although this study does include some methodological and experimental limitations, it provides an initial indication that family and community attitudes towards mental health is a significant barrier to professional help seeking and that self-compassion is associated with personal attitudes towards mental health. As with other studies, these results show how the opinion of others can impact on people's attitudes, even in situations where an individuals' health is at risk. Crucially, this study maintains the finding that family and community attitudes towards mental health have important impacts upon mental health help seeking. This suggests that interventions aimed at increasing mental health help seeking should focus on reducing perceived public stigma, specifically targeting the misconceptions about the levels of stigma held by the public, as this is more of a barrier to help seeking than personal stigma. Secondly, the results suggest that although self-compassion impacts on personal stigma, it does not impact upon help seeking, indicating that self-compassion may have an impact on the reduction of stigma but not on the attitudes towards help seeking that stigma can trigger. In future, studies should focus on the impact of self-compassion on other elements of stigma and analyse how compassionate-focused therapy can reduce stigma, which in turn will reduce the negative attitudes towards help seeking behaviour.

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## Appendices

### Appendix A – Self-compassion scale

| Almost Never | Occasionally | About Half of the Time | Fairly Often | Almost Always | Prefer not to answer |
|---|---|---|---|---|---|

1. I'm disapproving and judgmental about my own flaws and inadequacies.
2. When I'm feeling down I tend to obsess and fixate on everything that's wrong.
3. When things are going badly for me, I see the difficulties as part of life that everyone goes through.
4. When I think about my inadequacies, it tends to make me feel more separate and cut off from the rest of the world.
5. I try to be loving towards myself when I'm feeling emotional pain.
6. When I fail at something important to me I become consumed by feelings of inadequacy.
7. When I'm down and out, I remind myself that there are lots of other people in the world feeling like I am.
8. When times are really difficult, I tend to be tough on myself.
9. When something upsets me I try to keep my emotions in balance.
10. When I feel inadequate in some way, I try to remind myself that feelings of inadequacy are shared by most people.
11. I'm intolerant and impatient towards those aspects of my personality I don't like.
12. When I'm going through a very hard time, I give myself the caring and tenderness I need.
13. When I'm feeling down, I tend to feel like most other people are probably happier than I am.
14. When something painful happens I try to take a balanced view of the situation.
15. I try to see my failings as part of the human condition.
16. When I see aspects of myself that I don't like, I get down on myself.
17. When I fail at something important to me I try to keep things in perspective.
18. When I'm really struggling, I tend to feel like other people must be having an easier time of it.
19. I'm kind to myself when I'm experiencing suffering.
20. When something upsets me I get carried away with my feelings.
21. I can be a bit cold-hearted towards myself when I'm experiencing suffering.
22. When I'm feeling down I try to approach my feelings with curiosity and openness.
23. I'm tolerant of my own flaws and inadequacies.
24. When something painful happens I tend to blow the incident out of proportion.
25. When I fail at something that's important to me, I tend to feel alone in my failure.
26. I try to be understanding and patient towards those aspects of my personality I don't like.

## Appendix B – Attitudes towards mental health problems scale

| Do not agree at all | Agree a little | Mostly agree | Completely agree | Prefer not to answer |
|---|---|---|---|---|

**For this first set of questions please think about how your community and family view mental health problems such as depression and anxiety with a difficulty to cope in everyday life.**

1. My community sees mental health problems as something to keep secret.
2. My community sees mental health problems as a personal weakness
3. My community would tend to look down on somebody with mental health problems
4. My community would want to keep their distance from someone with mental health problems
5. My family see mental health problems as something to keep secret
6. My family see mental health problems as personal weakness
7. My family would tend to look down on somebody with mental health problems
8. My family would want to keep their distance from someone with mental health problems

**For the next set of questions please think about how *you* might feel about yourself if you suffered from mental health problems such as depression and anxiety with a difficulty to cope in everyday life.**

9. I would see myself as inferior
10. I would see myself as inadequate
11. I would blame myself for my problems
12. I would see myself as a weak person
13. I would see myself as a failure

**Appendix C – Attitudes towards seeking professional help short form**

| Disagree | Partly Disagree | Partly Agree | Agree | Prefer not to answer |
|---|---|---|---|---|

1. If I believed I was having a mental breakdown, my first inclination would be to get professional attention.
2. The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts.
3. If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in psychotherapy.
4. There is something admirable in the attitude of a person who is willing to cope with his or her conflicts and fears without resorting to professional help.
5. I would want to get psychological help if I were worried or upset for a long period of time.
6. I might want to have psychological counselling in the future.
7. A person with an emotional problem is not likely to solve it alone; he or she is likely to solve it with professional help.
8. Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me.
9. A person should work out his or her own problems; getting psychological counselling would be a last resort.
10. Personal and emotional troubles, like many things, tend to work out by themselves.

## Appendix D – Ethics application

*Staff / Office Use Only* ***DOPEC NUMBER:*** _____

***Umbrella project DOPEC number (staff)***_____

*APPLICANT SURNAME: JONES*

**Please complete all questions by underlining the correct response to facilitate correct processing**

**APPLICANT:** **UG** **PGT** **PGR** **STAFF**

**REVIEW PROCESS:** **Accelerated / Full**

**APPLICATION STATUS:** **NEW APPLICATION, MAJOR AMENDMENT, RESUBMISSION**

**APPLICATION FOR:** **DISSERTATION, TEACHING, RESEARCH & PUBLICATION**

**ATTTENDENCE AT HEALTH & SAFETY BRIEFING:** **YES / NO / NA**

**INCLUSION OF RISK ASSESSMENT FORM:** **YES / NO / NA**

**NOTES ON THE ROLE AND FUNCTION OF THE DEPARTMENT OF PSYCHOLOGY ETHICS COMMITTEE.**

- *All decisions of the committee are based on the application form and reviewers comments ONLY. Forms should be as detailed and clear as possible. Verbal discussions are not considered as part of the application or review process.*
- *The review process strictly adheres to the University of Chester Research Governance Handbook and the BPS Code of Ethics.*
- *The decision of the committee is final. If you are a UG, PGT or PGR student you should discuss the decision of the committee with your supervisor. If you are a member of staff you may contact the chair of the committee for further clarification.*

Before completing the form researchers are expected to familiarise themselves with the regulatory codes and codes of conduct and ethics relevant to their areas of research, including those of relevant professional organisations and ensure that research which they propose is designed to comply with such codes.
Department of Psychology Ethical Approval for Research: Procedural Guidelines.
University of Chester Research Governance Handbook
http://ganymede2.chester.ac.uk/view.php?title_id=522471
BPS Code of Ethics
http://www.bps.org.uk/system/files/Public%20files/bps_code_of_ethics_2009.pdf
BPS Code of Human Research Ethics
http://www.bps.org.uk/sites/default/files/documents/code_of_human_research_ethics.pdf
BPS Guidelines for Internet-mediated Research
http://www.bps.org.uk/system/files/Public%20files/inf206-guidelines-for-internet-mediated-research.pdf
BPS Research Guidelines and Policy Documents
http://www.bps.org.uk/publications/policy-and-guidelines/research-guidelines-policy-documents/research-guidelines-poli

Any queries email: psychology_ethics@chester.ac.uk

## CHECK LIST.

Please complete the form below indicating attached materials. Prior to submission supervisors must confirm that they have reviewed the application by completing the supervisors column.

| *Notes: Students to indicate where information is found, supervisor to confirm by ticking green column* | Supervisor confirmation | sheetInformation. | Letter | Email | pageEmail info. | FormConsent | PowerPoint | N/A |
|---|---|---|---|---|---|---|---|---|
| Brief details about the purpose of the study | ☒ | ☒ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Contact details for further information | ☒ | ☒ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Explanation of how and why participant has been chosen | ☒ | ☒ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Notification that materials/interviews are not diagnostic tools/therapy or used for staff review/development purposes | ☒ | ☒ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Explanation participation is voluntary | ☒ | ☒ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Details of any incentives or compensation | ☒ | ☒ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Details of how consent will be obtained | ☒ | ☒ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| If research is observational, consent to being observed | ☒ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☒ |
| Details of procedure so participants are informed about what to expect | ☒ | ☒ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Details of time commitments expected | ☒ | ☒ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Details of any stimuli used | ☒ | ☒ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Explanation of right to withdraw and right to withdraw procedure | ☒ | ☒ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Option for omitting questions participant does not wish to answer | ☒ | ☒ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Procedure regarding partially completed questionnaires or interviews | ☒ | ☒ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| With interviews, information regarding time limit for withdrawal | ☒ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☒ |
| Details of any advantages and benefits of taking part | ☒ | ☒ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Details of any disadvantages and risks of taking part | ☒ | ☒ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Information that data will be treated with full confidentiality and that, if published, those data will not be identifiable as theirs | ☒ | ☒ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Debriefing details | ☒ | ☒ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Dissemination information | ☒ | ☒ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Further information (relevant literature; support networks etc) | ☒ | ☒ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

***Supervisor Signature:***
***Date:29.5.2017***

***IN COMPLETING THE FORM UG & PGT STUDENTS PLEASE REFER TO YOUR HANDBOOK***

**Question 1: Working title of the study**

*Notes: The title should be a single sentence*

The influence of mental health and physical health attitudes on the perception of professional help seeking; does gender and self-compassion play a role.

**Question 2: Applicant, name and contact details.**

*Notes: The primary applicant is the name of the person who has overall responsibility for the study. Include their appointment or position held and their qualifications. For studies where students and/or research assistants will undertake the research, the primary applicant is the student (UG, PGT, PGR) and supervisor is the co-applicant.*

Rebecca Jones
Psychology Masters Student
University of Chester
1620296@chester.ac.uk

**Question 3: Co-applicants**

*Notes: List the names of all researchers involved in the study. Include their appointment or position held and their qualifications.*

Dr Gemma Evans (BSc, MRes, PhD, ClinPsyD, CPsychol),
Gemma.evans@chester.ac.uk
Lecturer in Psychology and Clinical Psychologist
Room CCR125, Department of Psychology
University of Chester
Parkgate Road
Chester
CH1 4BJ
01244 511 949

**Question 4: What are the start and end dates of the study?**

*Notes: If exact dates are unavailable, explain why and give approximate dates.*

The main umbrella project commenced after ethical approval in late April 2017 (DOPEC_GE20517). The main study will terminate once the required number of participants has been recruited, or in October 2018 at the latest.
The current submission refers to a student application to analyze a subset of variables from the main study and to collect data by advertising it using the students social media. The student will analyze the first 40 data points from a subset of study variables. The student will collect these data points by August 2017.

**Question 5: Is this project subject to external funding?**

*Notes: Please provide details of the funding body, grant application and PI.*

This project is not subject to external funding.

**Question 6: Briefly describe the purpose and rationale of the research**

*Notes: In writing the rationale make sure that the research proposed is grounded in relevant literature, and the hypotheses emerge from recent research and are logically structured.*
*PGR / Staff if this application is for a funded project please attach any detailed research proposals as appropriate.*
*Maximum word length (300 words)*

The purpose of the larger approved study (DOPEC_GE20517) as a whole is to ascertain whether gender and self-compassion play a role in the attitudes of both mental and physical health and whether this has an impact on perceptions of professional help seeking.

The student applicant will be analysing a subset of the data. The student will analyse the variables which examine whether self-compassion is related to attitudes towards mental and physical health as well as help seeking attitudes. Literature suggests that the stigma surrounding mental health has significant negative affects on help-seeking behaviours (Eisenberg et al, 2009). Opposing this, self-compassion, a positive self-attitude, is seen to promote mental well being (Neff, 2010). Literature surrounding the topic of self-compassion with links to help-seeking is limited, however there is growing literature recognizing the role of self compassion in mediating the effects of self-stigma and well-being. (Hilbert et al, 2015)

**Question 7: Describe the methods and procedures of the study**

*Notes: Attach any relevant material (questionnaires, supporting information etc.) as appendices and summarise them briefly here (e.g. Cognitive Failures Questionnaire: a standardised self-report measure on the frequency of everyday cognitive slips). Do not merely list the names of measures and/or their acronyms. Include information about any interventions, interview schedules, duration, order and frequency of assessments. It should be clear exactly what will happen to participants. If this is a media based study describe and list materials include links and sampling procedure. (500 words)*

The study uses self-report survey, which will be completed online. The wider approved study (DOPEC_ ge20517) will collect the following information and use the following measures (copies are provided in Appendix D).

- participant information including Gender, Age, Student status and Ethnicity.
- Self-compassion will be measured using the Self Compassion Scale (SCS; Neff, 2011)
- well-being will be measured using the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS; Platt et al, 2007).
- Physical health will be explored very briefly using a series of questions, which have been positively framed to minimize any distress.
- Attitudes towards mental health problems will be gathered using the Attitudes towards mental health problems scale (ATMHP; Gilbert et al, 2007). Only two of the five subscales of this questionnaire will be used. Three of the scales have been removed in order to reduce the likelihood of inducing negative emotion.
- The same two included scales will be adapted in the adapted Attitudes towards mental health problems scale (adaptedATMHP; Gilbert et al, 2007) in order to examine attitudes to physical health by replacing any question referring to 'mental health' with 'physical health'. The scale authors have granted permission for this adaptation.
- Attitudes Towards Seeking Professional Help Scale Short Form (ATSPH-SH; Fischer & Farina, 1995) will be used to explore views on seeking professional mental health help
- Attitudes Towards Medical Help Seeking Scale (ATMHSS; DiLorenzo, Dornelas & Fischer, 2015) will be used to assess views on seeking physical health help. A subscale of this broader scale will be used, which contains an action/ intention subscale.

All scales have been found to have evidence for reliability and validity.

The student will have access to the first 40 data points from the study, however the student will only analyse the following variables: self-compassion (SCS), attitudes towards mental health problems and attitudes towards physical health problems (ATMHP and adaptedATMHP) attitudes towards professional help seeking (ATSPH-SH and ATMHSS). The data will be provided to the student by the supervisor once 40 data points have been collected.

The main study has been approved for online advertisement via the RPS system and on the supervisors Facebook page, with an online recruitment message sent via social media. The current application is also requesting permission for the student applicant to advertise the study via her own facebook page. Online recruitment will proceed in the same way as for the main umbrella project, with a message being sent to potential participants and they will be required to private message the main applicant in order to receive the link to the study. This will be in an attempt to try to ensure that participants are over the age of 18 (messages for online recruitment are contained in Appendix F and Fb, with Fb containing a specific script for the student applicant).

Consistent with the approved existing project, before participants are able to answer the questionnaires they will be shown a participant information sheet (Appendix A) this is to provide participants with as much information as possible and ensure they are happy to take part. If participants proceed to answer the questions, it will be assumed that they are consenting to take part. Following participation, a debrief sheet will be presented (Appendix B). It is anticipated the survey will take 20-30 minutes to complete. All questionnaires included are not to be used as a diagnostic tool or for the use of therapy. For any individual scales that contain two or less missing data points, the data points will be replaced with the mean. However, if it is deemed that an individual has failed to answer multiple questions, then the data set may be withdrawn. Participants are not informed of this as a previous ethics application suggested that this may be considered coercion.

As a contingency to the student project, if 40 participants are not recruited by August 2017, then the student will reduce the number of variables to be analysed, instead looking at compassion, and attitudes towards professional help-seeking in mental and physical health. It is envisage that the student application will involve statistical analysis such as correlation, regression and potentially mediation analysis. Results of the wider approved study may be used in publications, although results of the students sub-analyses of the 40 data points will not be used in publications.

**Question 8: Has the person carrying out the study had previous experience of the procedures? If not, who will supervise that person?**

*Notes: Say who will be undertaking the procedures involved and what training and/or experience they have. If supervision is necessary, indicate who will provide it.*

The supervisor has experience of using the methodologies proposed. The student has attended the methodology lectures as part of the conversion psychology course.

**Question 9: What ethical issues does this study raise and what measures have been taken to address them?**

*Notes: Describe any discomfort or inconvenience that participants may experience. Include information about procedures that for some people could be physically stressful or might impact on the safety of participants, e.g. interviews, probing questions, noise levels, visual stimuli, equipment; or that for some people could be psychologically stressful, e.g. mood induction procedures, tasks with high failure rate. Discuss any issues of anonymity and confidentiality as they relate to your study, refer to ethics handbook and guidance notes at the end of the form. If animal based include ethical issues relating to observation.*

All the ethical issues are the same as the approved application for the umbrella project.

- Informed consent will be sought prior to participation. A participant information sheet will be provided (see appendix A). It will be assumed that if participants proceed to complete the questionnaire then they are providing informed consent. It will also be assumed that if they proceed they are agreeing that they meet the necessary eligibility criteria to participate.
- A debrief form will also be provided (see appendix B).
- No deception is used in the study.
- In the participant information sheet, participants are advised that some of the questions do ask about views of how the participant, their community and family view mental health difficulties such as anxiety and depression, and physical health difficulties such as chronic pain. The participant is advised that if answering questions related to this topic is likely to lead to any potential difficulties or potentially raise any personal memories or concerns, for example if themselves or a family member has experienced physical or mental health difficulties, then they should carefully consider whether or not to participate. Participants are also informed that they will be asked to answer questions about their own well-being (e.g. I've been feeling relaxed), about their physical health and about their views of seeking professional help for emotional or physical health problems. Whilst the questionnaires are not anticipated to result in significant distress, participants will be advised in the debrief form (appendix B) that if they feel that further support is needed then they should consider contacting their GP or other sources of support such as the Samaritans or student welfare.
- Participants will not be required to provide their name or any identifiable information

**Question 10: Who will the participants be?**

*Notes: Describe the groups of participants that will be recruited and the principal eligibility criteria and ineligibility criteria. Make clear how many participants you plan to recruit into the study in total.*

This main study (DOPEC_GE20517) will aim to recruit around 150 participants as power analysis has indicated that this is likely to be a sufficient sample size given the number of questionnaires administered. The student will be analyzing the first 40 participants' data for the purpose of the thesis.

The only eligibility criterion is that participants are over the age of 18 years old. This information will be provided in the participant information sheet. Participants will be

**Question 11: Describe participant recruitment procedures for the study**

*Notes: Gives details of how potential participants will be identified or recruited. Include all advertising materials (social media messages, posters, emails, letters, verbal script etc.) as appendices and refer to them as appropriate. Describe any screening examinations. If it serves to explain the procedures better, include as an appendix a flow chart and refer to it.*

The larger umbrella study that has already gained ethical approval will continue to recruit participants in the following ways:
1) Online. The study will be advertised through social media. The study will be following the ethics guidelines for recruiting via social media.
2) Students will be recruited via the RPS system and via advertisement on the university of Chester campus (see appendix).

This student application will add the following recruitment method:
3)Online via student applicant. The student will advertise the study through social media. The study will be following the ethics guidelines for recruiting via social media. The study will be advertised via the student applicants Facebook account. This will be in the same way as previously approved for the umbrella project. The link to the study will be sent to participants only after they have expressed interest in the study by contacting the researcher. The link will direct participants to the online study, contained on Bristol online surveys. Please see Appendix for scripts and procedures.

**Question 12: Describe the procedures to obtain informed consent**

*Notes: Describe when consent will be obtained. If consent is from **adult participants**, give details of who will take consent and how it will be done. If you plan to seek informed consent from **vulnerable groups** (e.g. people with learning difficulties, victims of crime), say how you will ensure that consent is voluntary and fully informed.*

*If you are recruiting **children or young adults** (aged under 18 years) specify the age-range of participants and describe the arrangements for seeking informed consent from a person with parental responsibility. If you intend to provide children under 16 with information about the study and seek agreement, outline how this process will vary according to their age and level of understanding.*

*How long will you allow potential participants to decide whether or not to take part? What arrangements have been made for people who might not adequately understand verbal explanations or written information given in English, or who have special communication needs?*

*If you are not obtaining consent, explain why not.*

This will be the same as for the already approved larger study.

- As all participants will be over the age of 18, informed consent will not be required for under 18s.
- Participants will be presented with the participant information sheet to read before participation. If participants proceed to complete the questionnaires, it will be assumed that they are consenting to participate.
- Participants will have as long as they require to decide whether to take part in the survey.
- As suggested, the only eligibility criteria is that participants are over the age of 18, and participants will be informed of this in the participant information sheet. Unfortunately it is beyond the scope of the current study to provide alternative questionnaires for individuals who are unable to understand written English.

**Question 13: Will consent be written?**

*Notes: If **yes**, include a consent form as an appendix. If **no**, describe and justify an alternative procedure (verbal, electronic etc.) in the space below.*

*Guidance on how to draft Participant Information sheet and Consent form can be found on PS6001 Moodle space and in the Handbook.*

This will be the same as for the larger approved study. Consent will not be written. The completion of the questionnaires will be assumed as consent to participate. Participants will view the participant information sheet (appendix A) and if they proceed to answer the questionnaires it will be assumed that they are happy to participate.

**Question 14: What will participants be told about the study? Will any information on procedures or the purpose of study be withheld?**

*Notes: Include an Information Sheet that sets out the purpose of the study and what will be required of the participant as appendices and refer to it as appropriate. If any information is to be withheld, justify this decision. More than one Information Sheet may be necessary.*

Again this is the same as for the already approved study. Participants will be told about the basic information surrounding the survey. No deception will be used.

**Question 15: Will personally identifiable information be made available beyond the research team (e.g. report to organisation)?**

*Notes: If so, indicate to whom and describe how confidentiality and anonymity will be maintained at all stages.*

Again this is the same as for the already approved study. No personally identifiable information will be recorded. All submitted data will be anonymous.

**Question 16: What payments, expenses or other benefits and inducements will participants receive?**

*Notes: Give details. If it is monetary say how much, how it will be paid and on what basis is the amount determined. Indicate RPS credits.*

Again this is the same as for the already approved study. Participants will receive no monetary benefits.
Chester university students using RPS will be awarded 2 credits for completing the survey.

**Question 17: At the end of the study, what will participants be told about the investigation?**

*Notes: Give details of debriefings, ways of alleviating any distress that might be caused by the study and ways of dealing with any clinical problem that may arise relating to the focus of the study.*

Again this is the same as for the already approved study.

- Participants will be given a full debrief of the study once they have finished the survey (see appendix). They will be told that we are researching the links between mental and physical health attitudes, help seeking views and the impacts of gender and self-compassion.
- They will be informed that they will not receive any further information about the study but if they would like to see the results of the project following data analysis they can email the researcher and a results summary will be provided when the study is completed. However this will not contain any individual results.
- Participants will also be provided with links to student support as well as mental health websites and helplines.

**Question 18: What arrangements are there for data security during and after the study?**

*Notes: Digital data stored on a computer requires compliance with the Data Protection Act; indicate if you have discussed this with your supervisor and describe any special circumstances that have been identified from that discussion. Say who will have access to participants' personal data and for how long personal data will be stored or accessed after the study has ended.*

Again this is the same as for the already approved study.

For the larger study: Digital data will be stored on password-protected computers. No personally identifiable information is required from participants and therefore will not be stored. Data will be stored for the length of time necessary for any publications that arise, and thereafter for the length of time required by any publishers. All data will be stored in anonymous form.

For the current student application: Data will be managed by the supervisor who is the lead applicant on the already approved larger study. The supervisor will provide the student with the first 40 data points for analysis for the students thesis. As only a small number of participants has already been recruited for this study, it is envisaged that most of the 40 data points will consist of participants who are recruited via the students advertisement. The student will delete the data once this has been analysed for the purposes of the thesis. The data will however be retained by the main applicant as part of the larger study.

**Signatures of the study team (including date)**

*Notes: The primary applicant and all co-applicants must sign and date the form. Scanned or electronic signatures are acceptable.*

29.5.2017

Rjones 29.5.2017

**ETHICS COMMITTEE DATE:**

**CHAIRS COMMENTS:**

☐ **Read and address all reviewers comments**

**ACCEPTABLE**

☐ **Action: You may now commence with data collection subject to approval from any relevant external agencies.**

***DATA COLLECTION IS NOT PERMISSABLE UNDER THESE CONDITIONS***

☐ **ACCEPTABLE SUBJECT TO SUBMISSION OF AMENDMENT FORM**

☐ **Acceptable subject to conditions listed by chair. Discuss conditions highlighted with supervisor and submit ethics application amendment form direct to office.**

☐ **Acceptable subject to conditions listed by chair: Submit ethics application amendment form direct to office.**

**ACCEPTABLE SUBJECT TO CONDITIONS LISTED BY CHAIR:**

☐ **Action: Resubmit application for full review ensuring you have completed section B**

**REVISE AND RESUBMIT:**

☐ **Action: Resubmit application for full review ensuring you have completed section B**

**SIGNATURE: ……**

**Appendix: with the exception of appendix Fb, all of the following appendices have already been approved for the main study (DOPEC_GE20517)**

## Ethics Appendix A – Participant Information Sheet


### The influence of mental health and physical health attitudes on the perception of professional help seeking; does gender and self-compassion play a role.

You are invited to take part in a research project that is looking at the role of gender and self-compassion in mental health and physical health attitudes on the perception of professional help seeking. The research is being conducted by Dr Gemma Evans, who is a lecturer at the University of Chester.

**Introduction**

Self-compassion is often thought of as acting kindly towards ourselves. This study aims to explore whether self-compassion plays a role in the attitudes of both mental and physical health and whether this has an impact on perceptions of professional help seeking.

**What will I be asked to do if I take part?**

If you agree to take part you will be asked to complete a series of questionnaires. These will be online.

You will be asked some demographic information about your gender and age but no personally identifiable information will be required and we will not ask for your name.

You will then be asked to complete some questionnaires that ask about self-compassion, attitudes towards mental and physical health problems and attitudes towards seeking professional help for mental and physical health problems. You

are not required to answer any questions about whether you have ever received professional support for mental or physical health difficulties.

Please note that these questionnaires are not used as diagnostic tools and as the study is anonymous, it will not be possible to provide feedback on your score.

It is likely that the questionnaires will take between 20-30 minutes to complete.

**Why have I been asked to take part?**

The only requirement of the study is that participants are over 18 years of age. You have been asked to take part because we think that you may meet this criteria. We are recruiting for this study via the University of Chester, and also via social media. You may have been asked to take part because you have links with the research team through social media, or because you are a student or staff member at the University of Chester.

**How do I take part?**

Please read this information sheet and if you decide to take part simply continue and begin to answer the questions.

Taking part is voluntary. If you have further questions the researcher is happy to answer these. You do not need to decide about participation straight away if you feel that you need further time to consider this.

You do not need to answer every question presented if you decide that you would prefer not to answer that individual question.

**What are the possible benefits or risks to you of taking part?**

Some of the questionnaires do ask you about your views on mental and physical health and about your own well-being. For example, some of the questions ask you about your views of how your family or community feel about mental health and physical health problems (e.g. My community sees mental health problems as something to keep secret) and asks you to consider how you might feel if *you*

suffered from mental health problems such as depression and anxiety or a physical health problem like chronic pain.

If for any reason you feel that answering questions about your views on mental health difficulties, such as anxiety and depression, and physical health difficulties, such as chronic pain, may lead to distressing thoughts or memories (for example, if you or a family member has suffered from mental or physical health issues) then we would strongly advise you to carefully consider whether you feel that there may be risks for you of taking part, and if so, you may wish to decline. You do not need to tell the researcher your reasons for declining to take part.

If you do wish to withdraw at any point after you have begun then simply stop answering the questions and close the survey. The researcher will take this as a sign that you wish to withdraw and will not include your data in the final project. You do not need to explain to the researcher why you have chosen to withdraw. As the questionnaires are anonymous, it is not possible to withdraw your data once you have completed the questionnaires.

If for any reason you feel that you may need further emotional support we would advise you to consider seeking advice from your GP. You may also wish to consider contacting a source of talking support, such as the Samaritans. The Samaritans can be contacted for free at any time on 116 123. Websites such as www.mind.org.uk also provide support and information surrounding mental health. If you are a student from the University of Chester, you can also gain support from student welfare.

We are unable to offer payment for your participation. If you are a student at the University of Chester you can receive 2 credits via the RPS system.

**How will my answers to the questionnaires be used?**

Completed questionnaires will be stored on password-protected computers. No identifiable information is required in the questionnaires, so your data is anonymous. The anonymous data may be used in future publications or other forms of dissemination that arise from the work.

**Thank you for reading this information sheet. If you wish to take part then please continue and answer the questions.**

**The Department of Psychology Research Ethics Committee have reviewed and approved this study.**

Dr Gemma Evans
Gemma.evans@chester.ac.uk
01244511949

## Ethics Appendix B - Debrief Sheet

University of Chester

## The influence of mental health and physical health attitudes on the perception of professional help seeking; does gender and self-compassion play a role.

Thank you for taking part in the study.

As explained in the participant information sheet, your answers will now be used to help us to understand the relationships between physical and mental health perceptions and beliefs about help seeking, as well as the impact of gender and self-compassion within this relationship.

No identifiable information was requested in the questions, so your participation is anonymous.

We hope that you found completing the questionnaires interesting. We are particularly interested in understanding how views of mental health and physical health can impact help seeking. This is important as we know that around 1 in 4

people in the UK experiences mental health problems each year. If you would like more information about this then websites like www.mind.org.uk and https://www.time-to-change.org.uk maybe helpful.

We do not anticipate that the questions asked will have been distressing, however if for any reason you feel that you may need further support as a result of any emotional distress then we would advise you to consider seeking advice from your GP. You may also wish to consider contacting a source of talking support, such as the Samaritans. The Samaritans can be contacted for free at any time on 116 123 or www.samaritans.org. If you are a student at The University of Chester you can also contact student support and guidance.

On the next page there is also a list of entertaining videos and exerts that you may want to look. If you have any further questions please feel free to contact the researcher.

Dr Gemma Evans
Gemma.evans@chester.ac.uk
01244511949

## Ethics Appendix D - Survey

**Thank you for agreeing to participate. By completing the questionnaires we are assuming the following:**

You are above the age of 18
You have read the participant information sheet
You have asked any questions that you have about the study
You understand that you are free to participate or not, without providing any reasons
You are free to withdraw at any point during the study, without providing any reasons
You agree for your anonymous data to be used for the purposes of this research project and any future publications or other forms of dissemination.

**Demographics**

Please select your gender:

| | |
|---|---|
| Male | |
| Female | |
| Rather not say | |
| Prefer to self specify | |

Please specify your age:

| |
|---|
| |

Please specify your ethnicity:

| |
|---|
| |

Are you currently a student?

| | |
|---|---|
| Yes | |
| No | |

Please insert your RPS credit number below to receive 2 credits (at the end of the survey)

**Self-Compassion Scale – Online Version** Please read each statement carefully before answering. Indicate how often you behave in the stated manner.

| | Almost Never | Occasion-ally | About Half of the Time | Fairly Often | Almost Always | Prefer not to answer |
|---|---|---|---|---|---|---|
| I'm disapproving and judgmental about my own flaws and inadequacies. | | | | | | |
| When I'm feeling down I tend to obsess and fixate on everything that's wrong. | | | | | | |
| When things are going badly for me, I see the difficulties as part of life that everyone goes through. | | | | | | |
| When I think about my inadequacies, it tends to make me feel more separate and cut off from the rest of the world. | | | | | | |
| I try to be loving towards myself when I'm feeling emotional pain. | | | | | | |
| When I fail at something important to me I become consumed by feelings of inadequacy. | | | | | | |
| When I'm down and out, I remind myself that there are lots of other people in the world feeling like I am. | | | | | | |
| When times are really difficult, I tend to be tough on myself. | | | | | | |
| When something upsets me I try to keep my emotions in balance. | | | | | | |
| When I feel inadequate in some way, I try to remind myself that feelings of inadequacy are shared by most people. | | | | | | |
| I'm intolerant and impatient towards those aspects of my personality I don't like. | | | | | | |
| When I'm going through a very hard time, I give myself the caring and tenderness I need. | | | | | | |
| When I'm feeling down, I tend to feel like most other people are probably happier than I am. | | | | | | |
| When something painful happens I try to take a balanced view of the situation. | | | | | | |
| I try to see my failings as part of the human condition. | | | | | | |
| When I see aspects of myself that I don't like, I get down on myself. | | | | | | |
| When I fail at something important to me I try to keep things in perspective. | | | | | | |
| When I'm really struggling, I tend to feel like other people must be having an easier time of it. | | | | | | |
| I'm kind to myself when I'm experiencing suffering. | | | | | | |
| When something upsets me I get carried away with my feelings. | | | | | | |
| I can be a bit cold-hearted towards myself when I'm experiencing suffering. | | | | | | |
| When I'm feeling down I try to approach my feelings with curiosity and openness. | | | | | | |
| I'm tolerant of my own flaws and inadequacies. | | | | | | |
| When something painful happens I tend to blow the incident out of proportion. | | | | | | |
| When I fail at something that's important to me, I tend to feel alone in my failure. | | | | | | |
| I try to be understanding and patient towards those aspects of my personality I don't like. | | | | | | |

**Mental well-being scale – Online version**

Below are some statements about feelings and thoughts. Please read each statement carefully before answering. Indicate the box that best describes your experience of each over the last 2 week using the scale:

Only select one box per statement.

| | None of the time | Rarely | Some of the time | Often | All of the time | Prefer not to answer |
|---|---|---|---|---|---|---|
| I've been feeling optimistic about the future | | | | | | |
| I've been feeling useful | | | | | | |
| I've been feeling relaxed | | | | | | |
| I've been feeling interested in other people | | | | | | |
| I've had energy to spare | | | | | | |
| I've been dealing with problems well | | | | | | |
| I've been thinking clearly | | | | | | |
| I've been feeling good about myself | | | | | | |
| I've been feeling close to other people | | | | | | |
| I've been feeling confident | | | | | | |
| I've been able to make up my own mind about things | | | | | | |
| I've been feeling loved | | | | | | |
| I've been interested in new things | | | | | | |
| I've been feeling cheerful | | | | | | |

**Physical Health Questions – Online version**

Please read each question carefully before answering. To the right of each questions, please indicate the most appropriate answer. Only select one box per question.

| In general, would you say your health is: | Excellent | Good | Fair | Poor | Very Poor | Prefer not to answer |
|---|---|---|---|---|---|---|
| How free from pain have you been over the past month? | No Pain at all | Mild Pain Yes always | Moderate Pain Yes Fairly Often | Severe Pain Yes sometimes | Very Severe Pain Yes but rarely | Prefer not to answer Yes but very rarely |
| In the last month has your physical health enabled you to complete everyday activities? (e.g. work, university, house work) | | | | | | |

**Attitudes towards mental health problems – Online Version**

**For this first set of questions please think about how your community and family view mental health problems such as depression and anxiety with a difficulty to cope in everyday life.**

Read each statement carefully and indicate the number that best describes how much you agree with each statement using the following scale:

Only select one box per question.

| | Do not agree at all | Agree a little | Mostly agree | Completely agree | Prefer not to answer |
|---|---|---|---|---|---|
| My community sees mental health problems as something to keep secret. | | | | | |
| My community sees mental health problems as a personal weakness | | | | | |
| My community would tend to look down on somebody with mental health problems | | | | | |
| My community would want to keep their distance from someone with mental health problems | | | | | |
| My family see mental health problems as something to keep secret | | | | | |
| My family see mental health problems as personal weakness | | | | | |
| My family would tend to look down on somebody with mental health problems | | | | | |
| My family would want to keep their distance from someone with mental health problems | | | | | |

**For the next set of questions please think about how *you* might feel about yourself if you suffered from mental health problems such as depression and anxiety with a difficulty to cope in everyday life.**

Read each statement carefully and indicate the number that best describes how much you agree with each statement using the following scale:

Only select one box per question.

| | Do not agree at all | Agree a little | Mostly agree | Completely agree | Prefer not to answer |
|---|---|---|---|---|---|
| I would see myself as inferior | | | | | |
| I would see myself as inadequate | | | | | |
| I would blame myself for my problems | | | | | |
| I would see myself as a weak person | | | | | |
| I would see myself as a failure | | | | | |

**Adapted ATMHP – Online Version**

**We are interested in people's thoughts and feelings about physical health problems. As you may know, some people suffer from physical health problems, such as chronic pain. These can make it difficult to cope with everyday life. People in chronic pain can find everyday activities difficult, they may have difficulties sleeping and concentrating. Below are a series of statements about how you, your community and your family may think about such problems.**

**For this first set of questions please think about how your community and family view physical health problems such as chronic pain with a difficulty to cope in everyday life.**

Read each statement carefully and indicate the number that best describes how much you agree with each statement using the following scale:

Only select one box per question.

| | Do not agree at all | Agree a little | Mostly agree | Completely agree | Prefer not to answer |
|---|---|---|---|---|---|
| My community sees physical health problems as something to keep secret | | | | | |
| My community sees physical health problems as a personal weakness | | | | | |
| My community would tend to look down on somebody with physical health problems | | | | | |
| My community would want to keep their distance from someone with physical health problems | | | | | |
| My family see physical health problems as something to keep secret | | | | | |
| My family see physical health problems as personal weakness | | | | | |
| My family would tend to look down on somebody with physical health problems | | | | | |
| My family would want to keep their distance from someone with physical health problems | | | | | |

**For the next set of questions please think about how you might feel about yourself if you suffered from physical health problems such as chronic pain with a difficulty to cope in everyday life.**

Read each statement carefully and indicate the number that best describes how much you agree with each statement using the following scale:

Only select one box per question.

| | Do not agree at all | Agree a little | Mostly agree | Completely agree | Prefer not to answer |
|---|---|---|---|---|---|
| I would see myself as inferior | | | | | |
| I would see myself as inadequate | | | | | |
| I would blame myself for my problems | | | | | |
| I would see myself as a weak person | | | | | |
| I would see myself as a failure | | | | | |

**Attitudes Towards Seeking Mental Health Input – Online Version**

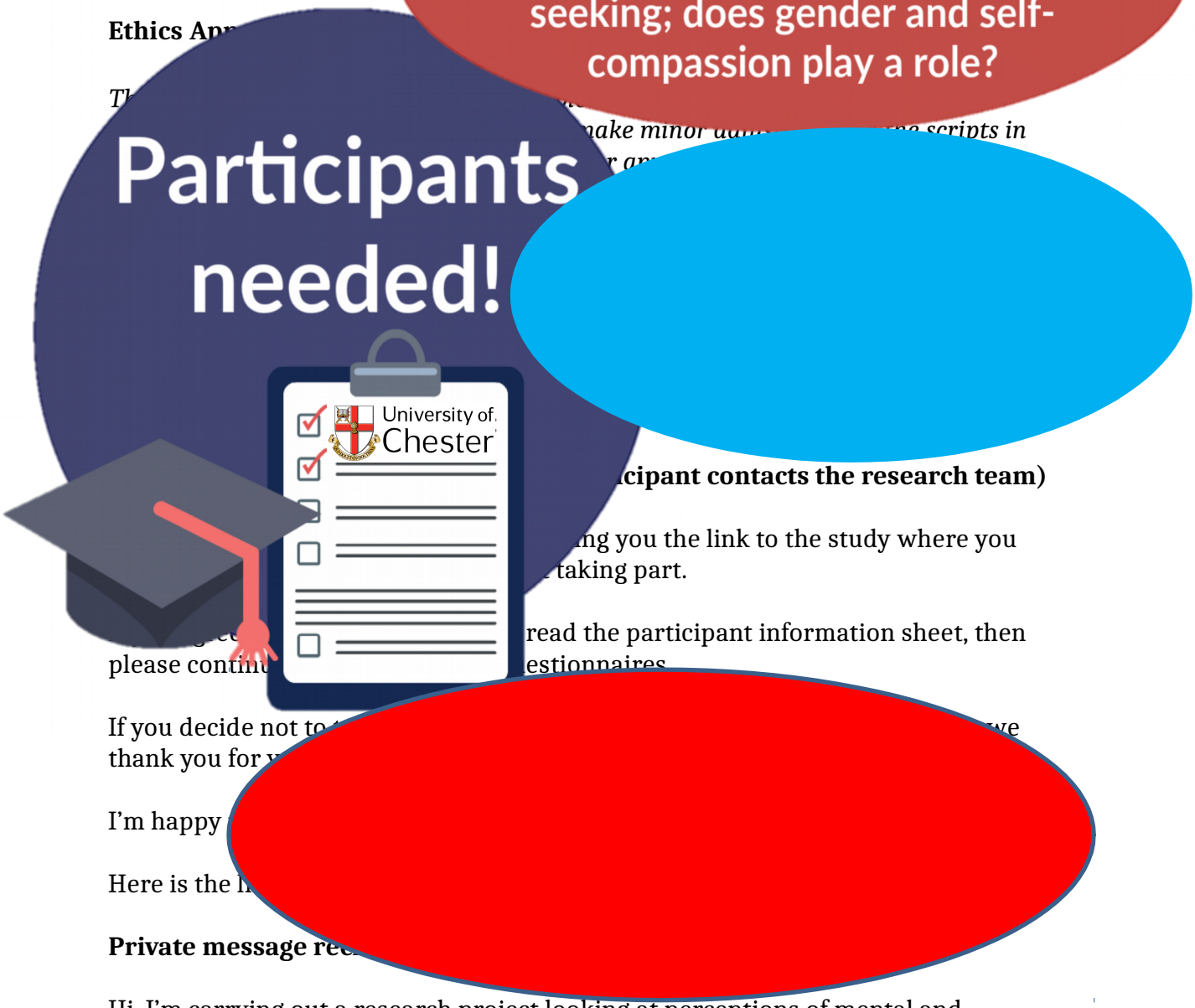
Read each statement carefully and tick the box that best describes your degree of agreement using the scale:
Only tick one box per question.

| | Disagree | Partly Disagree | Partly Agree | Agree | Prefer not to answer |
|---|---|---|---|---|---|
| If I believed I was having a mental breakdown, my first inclination would be to get professional attention. | | | | | |
| The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts. | | | | | |
| If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in psychotherapy. | | | | | |
| There is something admirable in the attitude of a person who is willing to cope with his or her conflicts and fears without resorting to professional help. | | | | | |
| I would want to get psychological help if I were worried or upset for a long period of time. | | | | | |
| I might want to have psychological counselling in the future. | | | | | |
| A person with an emotional problem is not likely to solve it alone; he or she is likely to solve it with professional help. | | | | | |
| Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me. | | | | | |
| A person should work out his or her own problems; getting psychological counselling would be a last resort. | | | | | |
| Personal and emotional troubles, like many things, tend to work out by themselves. | | | | | |

**Attitudes Towards Medical Help-Seeking Scale – Online version**

| | Disagree | Partly Disagree | Partly Agree | Agree | Prefer not to answer |
|---|---|---|---|---|---|
| I would rather live with some physical problems than go through a lot of medical tests and check-ups. | | | | | |
| I would want to get medical help right away if I had a health problem that was worrying me. | | | | | |
| If I have what I think is a medical symptom (such as continuous pain or a suspicious lump), I go to the doctor right away to have it checked. | | | | | |
| Considering all the time and expense connected with medical check-ups, and the inconclusive results they come up with, routine check-ups are hardly worth the bother. | | | | | |
| I always have a doctor that I trust, who knows me and my medical situation thoroughly. | | | | | |
| When I have doubts or questions about my physical health I find out what is wrong from a medical professional | | | | | |
| I would never go for more than a year without seeing my doctor, at least for a check-up | | | | | |
| If I had a physical problem that I thought could be serious I would contact a doctor or go to a hospital emergency room without hesitation | | | | | |
| I would willingly talk about personal problems with a doctor if I thought it could help me, or a member of my family | | | | | |
| If I have a serious symptom such as continuous pain, bleeding, or coughing, I call for an appointment right away | | | | | |
| Even when I know I probably should go to the doctor, I tend to put it off | | | | | |
| If I believed I had a potentially serious medical problem my first action would be to get professional attention for it | | | | | |

**Ethics Appendix E – Poster advertisement for recruitment**




**Ethics App**

*Th* *make minor* *scripts in* *r ap*

**icipant contacts the research team)**

ng you the link to the study where you taking part.

read the participant information sheet, then please contin estionnaires

If you decide not to we thank you for y

I'm happy

Here is the li

**Private message rec**

Hi. I'm carrying out a research project looking at perceptions of mental and physical health, help-seeking and self-compassion. Would you be interested in considering taking part? Thank you in advance.

**Yes response**

Great! I'm sending you the link to the study where you will find some more information about taking part.

If you agree to take part once you've read the participant information sheet, then please continue and complete the questionnaires.

If you decide not to take part after reading the participant information sheet, we thank you for your consideration.

I'm happy to answer any further questions you have.

Here is the link _____.

**No response**

Sorry to have troubled you, I won't contact you about this again.

## Appendix Fb – Recruitment Scripts for the student applicant

*The scripts will be used as much as possible to navigate conversations around recruitment. If needed the researcher will make minor adjustments to the scripts in line with the participants requirements, or for any scenarios that have not been anticipated.*

### Facebook message

Hi. I'm involved in a research project looking at perceptions of mental and physical health, help-seeking and self-compassion. The main project is being carried out by my supervisor, but I will analyse some of the data for my thesis. If you are above 18 years old, and would be interested in taking part or finding out more information then please private message me. Thank you in advance.

### Private message script (if a potential participant contacts the research team)

Great, thanks for contacting me. I'm sending you the link to the study where you will find some more information about taking part.

If you agree to take part once you've read the participant information sheet, then please continue and complete the questionnaires.

If you decide not to take part after reading the participant information sheet, we thank you for your consideration.

I'm happy to answer any further questions you have.

Here is the link _____.

### Private message recruitment

Hi. I'm involved in a research project looking at perceptions of mental and physical health, help-seeking and self-compassion. The main project is being carried out by my supervisor, but I will analyse some of the data for my thesis. Would you be interested in taking part or finding out more information? Thank you in advance

### Yes response

Great! I'm sending you the link to the study where you will find some more information about taking part.

If you agree to take part once you've read the participant information sheet, then please continue and complete the questionnaires.

If you decide not to take part after reading the participant information sheet, we thank you for your consideration.

I'm happy to answer any further questions you have.

Here is the link _____.

**No response**

Sorry to have troubled you, I won't contact you about this again.

## Appendix G – positive mood induction text

Here are some exerts and videos that we find funny:

These excerpts are taken from genuine exams papers and student essays:
- A fairy tale is something that never happened a long time ago.
- Nets are holes surrounded by pieces of string.
- The USSR and the USA became global in power, but Europe remained incontinent.
- The largest mammals are to be found in the sea because there is nowhere else to put them.
- If teeth are not cleaned, plague is the result.
- The wife of a duke is a dukky.
- An abstract noun is one that cannot be heard, seen touched or smelt.
- The appendix is a part of a book for which nobody ever found a use.
- A consonant is a large piece of land surrounded by water.
- In some rocks there are to be found the fossil footprints of fishes.
- Joan of Arc was Noah's sister.

Sneezing baby panda: https://www.youtube.com/watch?v=93hq0YU3Gqk
Funny penguin videos: https://www.youtube.com/watch?v=B2T_TqSP7DU
Cockatoo peekaboo: https://www.youtube.com/watch?v=I77-B7RrrPw
Laughing owl: https://www.youtube.com/watch?v=psmO9nTJFBw

## Appendix E – Ethics amendment form

University of Chester

**UNIVERSITY OF CHESTER, DEPARTMENT OF PSYCHOLOGY**
**APPLICATION FOR ETHICAL APPROVAL AMENDMENT FORM**

**A) Applicant and personnel**

**Applicant:** *Rebecca Jones*
**Project title**: The influence of mental health and physical health attitudes on the perception of professional help seeking; does gender and self-compassion play a role.
**Applicant status:** ☐ Staff → Go to Section B ☐PGR ☐Undergraduate ☒Postgraduate taught
**Supervisor**: *Dr Gemma Evans*

**B) Declaration**

1. ☒ I have submitted an application for ethical approval to the Department of Psychology Ethics Committee and I am required to make the following amendments to my application.
   List the recommendations of the committee. *Reviewer made the following points: 1) please clarify has the 40 data points already been achieved? 2) if the applicant is intending to recruit participants herself then she needs to add her name and contact details to the information sheet and debrief. 3) As the student will be recruiting via social media Im unsure why some of the appendices have been included (e.g. poster).*
   Describe how you have addressed these requirements. *1) as part of the wider umbrella project recruitment has commenced via the RPS system. 40 participants have not as yet been recruited as this project has only been recruiting for a short period of time. The student will recruit via social media. The student will have access to the first 40 data points. 2) an amendment has been made to the PIS and debrief form to include the students name and to be clear that other forms of dissemination includes masters projects. The students details will be removed once the first 40 participants have been recruited. 3) The poster is included as this is part of the umbrella project.*

2. ☐ I have submitted an application for ethical approval to the Department of Psychology Ethics Committee that was approved on Click here to enter a date.
   I wish the committee to consider the following amendments I would like to make to the research plan (attach the original approved application form) *Click here to enter text.*

☐ I am a member of staff. **Signed:** _____ **Date:** Click here to enter a date.
Print the amendment form on BLUE PAPER and submit to the Dept. Office
☒ I am an UG/PGT/PGR student. I have discussed any amendments with my project supervisor.

**COMMITTEE COMMENTS:**
☑ **ACCEPTABLE: You may now commence with data collection subject to approval from any relevant external agencies.**

***DATA COLLECTION IS NOT PERMISSABLE UNDER THESE CONDITIONS***
☐ **ACCEPTABLE SUBJECT TO SUBMISSION OF FURTHER AMENDMENT FORM.**
☐ **Acceptable subject to conditions listed by chair. Discuss conditions highlighted with supervisor and submit ethics application amendment form direct to office.**

☐ Acceptable subject to conditions noted by chair [illegible]
direct to office.

**Signed:** Moira E-Hafferty **Date:** Click here to enter a date. 30/6/17

Mark as unread

REBECCA JONES
Mon 26/06/2017 19:40
To:

–
...
1 attachment

Department –.docx
54 KB Open in browser

Hi Gemma,

I agree to the changes that have been highlighted on the amendment form. I have attached the form with my signature.

Regards,
Becca

Please note Rebecca unable to attend university to sign

students signature above.
Students electronic signature
not visible on front page,
and student unable to
paste elsewhere into form
due to form restrictions.

Thanks.

**Appendix F – SPSS output**

**Means and SDs for the measures**

**Item Statistics**

| | Mean | Std. Deviation | N |
|---|---|---|---|
| OVERALL_SCS_MEAN | 3.0088 | .73771 | 40 |
| SUMOFCOMMUNITY AND FAMILY_MH | 13.1500 | 4.63294 | 40 |
| SUMOF_PERSONAL_MH | 11.2250 | 5.10649 | 40 |
| SUM_ATT_PROF_MH | 27.7500 | 5.48541 | 40 |

**Cronbach's Alpha**

**SCS**

**Reliability Statistics**

| Cronbach's Alpha | Cronbach's Alpha Based on Standardized Items | N of Items |
|---|---|---|
| .821 | .818 | 6 |

**Community and Family attitudes towards mental health**

**Reliability Statistics**

| Cronbach's Alpha | Cronbach's Alpha Based on Standardized Items | N of Items |
|---|---|---|
| .835 | .839 | 8 |

**Personal attitudes towards mental health**

**Reliability Statistics**

| Cronbach's Alpha | Cronbach's Alpha Based on Standardized Items | N of Items |
|---|---|---|
| .947 | .947 | 5 |

**Attitudes towards professional help seeking**

**Reliability Statistics**

| Cronbach's Alpha | Cronbach's Alpha Based on Standardized Items | N of Items |
|---|---|---|
| .776 | .773 | 10 |

**Shapiro-Wilk**

**Tests of Normality**

| | Kolmogorov-Smirnov[a] | | | Shapiro-Wilk | | |
|---|---|---|---|---|---|---|
| | Statistic | df | Sig. | Statistic | df | Sig. |
| OVERALL_SCS_MEAN | .069 | 40 | .200* | .982 | 40 | .759 |
| SUMOFCOMMUNITY AND FAMILY_MH | .179 | 40 | .002 | .896 | 40 | .001 |
| SUMOF_PERSONAL_MH | .171 | 40 | .005 | .897 | 40 | .002 |
| SUM_ATT_PROF_MH | .140 | 40 | .046 | .960 | 40 | .165 |

*. This is a lower bound of the true significance.

a. Lilliefors Significance Correction

**Correlations**

| | | | | SUMOF_PERSONAL_MH | SUM_ATT_PROF_MH |
|---|---|---|---|---|---|
| Spearman's rho | SUMOF_PERSONAL_MH | Correlation Coefficient | | 1.000 | -.077 |
| | | Sig. (2-tailed) | | . | .638 |
| | | | | 40 | 40 |
| | | Bootstrap[c] | Bias | .000 | .005 |
| | | | Std. Error | .000 | .169 |
| | | | BCa 95% Confidence Interval Lower | . | -.406 |
| | | | BCa 95% Confidence Interval Upper | . | .232 |
| | SUM_ATT_PROF_MH | Correlation Coefficient | | -.077 | 1.000 |
| | | Sig. (2-tailed) | | .638 | . |

| | | | | | |
|---|---|---|---|---|---|
| | | | | 40 | 40 |
| | | Bootstrap[c] | Bias | .005 | .000 |
| | | | Std. Error | .169 | .000 |
| | | | BCa 95% Confidence Interval | Lower | -.406 | . |
| | | | | Upper | .232 | . |

c. Unless otherwise noted, bootstrap results are based on 1000 bootstrap samples

**Correlations**

| | | | | SUMOFCOMMUNITY AND FAMILY_MH | SUM_ATT_PROF_MH |
|---|---|---|---|---|---|
| Spearman's rho | SUMOFCOMMUNITY AND FAMILY_MH | Correlation Coefficient | | 1.000 | -.389* |
| | | Sig. (2-tailed) | | . | .013 |
| | | | | 40 | 40 |
| | | Bootstrap[c] | Bias | .000 | .006 |
| | | | Std. Error | .000 | .126 |
| | | | BCa 95% Confidence Interval | Lower | . | -.620 |
| | | | | Upper | . | -.073 |
| | SUM_ATT_PROF_MH | Correlation Coefficient | | -.389* | 1.000 |
| | | Sig. (2-tailed) | | .013 | . |
| | | | | 40 | 40 |
| | | Bootstrap[c] | Bias | .006 | .000 |
| | | | Std. Error | .126 | .000 |
| | | | BCa 95% Confidence Interval | Lower | -.620 | . |
| | | | | Upper | -.073 | . |

*. Correlation is significant at the 0.05 level (2-tailed).

c. Unless otherwise noted, bootstrap results are based on 1000 bootstrap samples

**Correlations**

| | | | | OVERALL_SCS_MEAN | SUMOF_PERSONAL_MH |
|---|---|---|---|---|---|
| Spearman's rho | OVERALL_SCS_MEAN | Correlation Coefficient | | 1.000 | -.534** |
| | | Sig. (2-tailed) | | . | .000 |
| | | | | 40 | 40 |
| | | Bootstrap[c] | Bias | .000 | .013 |
| | | | Std. Error | .000 | .146 |
| | | | BCa 95% Confidence Interval | Lower | . | -.801 |
| | | | | Upper | . | -.178 |
| | SUMOF_PERSONAL_MH | Correlation Coefficient | | -.534** | 1.000 |
| | | Sig. (2-tailed) | | .000 | . |
| | | | | 40 | 40 |

| | | | | | |
|---|---|---|---|---|---|
| | | Bootstrap[c] | Bias | .013 | .000 |
| | | | Std. Error | .146 | .000 |
| | | | BCa 95% Confidence Interval | Lower | -.801 | . |
| | | | | Upper | -.178 | . |

**. Correlation is significant at the 0.01 level (2-tailed).

c. Unless otherwise noted, bootstrap results are based on 1000 bootstrap samples

**Correlations**

| | | | | OVERALL_SCS_MEAN | SUM_ATT_PROF_MH |
|---|---|---|---|---|---|
| Spearman's rho | OVERALL_SCS_MEAN | Correlation Coefficient | | 1.000 | -.041 |
| | | Sig. (2-tailed) | | . | .800 |
| | | | | 40 | 40 |
| | | Bootstrap[c] | Bias | .000 | -.001 |
| | | | Std. Error | .000 | .159 |
| | | | BCa 95% Confidence Interval | Lower | . | -.355 |
| | | | | Upper | . | .264 |
| | SUM_ATT_PROF_MH | Correlation Coefficient | | -.041 | 1.000 |
| | | Sig. (2-tailed) | | .800 | . |
| | | | | 40 | 40 |
| | | Bootstrap[c] | Bias | -.001 | .000 |
| | | | Std. Error | .159 | .000 |
| | | | BCa 95% Confidence Interval | Lower | -.355 | . |
| | | | | Upper | .264 | . |

c. Unless otherwise noted, bootstrap results are based on 1000 bootstrap samples